DOCUMENT RESUME

ED 233 258 CG 016 835

AUTHOR	Hengstenberg, James D.; Lennox, Carolyn
TITLE	Answering the Cry for Help.
INSTITUTION	Texas Univ., Austin. Hogg Foundation for Mental Health.
PUB DATE	82
NOTE	18p.
AVAILABLE FROM	Hogg Foundation Publications Division, Box 7998, University of Texas, Austin, TX 78712 (1-24 copies, $0.35 ea.; 25-49 copies, $0.34 ea; 50-99 copies, $0.32 ea; over 100, $.30 ea.).
PUB TYPE	Reports - Descriptive (141)
EDRS PRICE	MF01 Plus Postage. PC Not Available from EDRS.
DESCRIPTORS	Behavior Problems; *Coping; Counseling Services; Counseling Techniques; *Crisis Intervention; Death; Emotional Disturbances; Grief; Hot Lines (Public); Life Satisfaction; Mental Health Programs; *Prevention; Program Descriptions; Social Support Groups; *Suicide

ABSTRACT

This pamphlet, produced by the Suicide and Crisis Center (SCC) of Dallas, Texas, presents information about suicide and describes several SCC programs in six brief sections. The extent of the suicide problem is discussed, and indicators of suicidal intent are described; factors affecting suicidal people, such as emotional turmoil, constricted thinking, and stressful situations, are also presented. Problems facing institutions, professionals, and lay people who work to prevent suicide (lack of knowledge, lack of funding, fear, and social stigma) are explored. The development, structure, and programs of the SCC are briefly presented. The SCC's Suicide Attempters Program, which consists of three services--education for hospital emergency room personnel, outreach services to clients who are at immediate risk for a suicide attempt, and support groups for recent suicide attempters--is described. A final section briefly discusses the structure, efficiency, and continued need for crisis intervention programs. (WAS)

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ANSWERING THE CRY FOR HELP

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ACKNOWLEDGMENTS

The Suicide and Crisis Center has always been a setting in which openness, honesty, and vulnerability flow freely and where personal growth is stimulated. This work is dedicated to the staff and board members who have responded to and met a major community need with integrity and professionalism. . .to the mental health and human service professionals who have provided a cooperative network and quality standards. . .to lay persons who had a vision and made it work. . .and, most of all, to hundreds of volunteers who have created by their sacrifice, dedication, and skill a unique family of love.

James D. Hengstenberg
Executive Director
The Suicide and Crisis Center

INTRODUCTION

"Life is not worth living."
"He (She) will be sorry when I'm gone."
Those words might be spoken by those who make the decision to commit suicide.

Or

"How could he (she) have done this terrible act and left me alone?"
"What could I have done to prevent such a happening?"
Those are the words which might be spoken by persons close to someone who has committed suicide.

The act of self-destruction is fraught with taboos, so much so that family members often try to cover up a suicide. Those who have attempted to take their own lives exist with a sense of guilt and feeling of shame.

Yet suicides occur in every culture. There are the overt acts of death by gun or pill. There are covert acts of death by self-destruction via speeding, drinking, or, in the case of many older people, starvation.

Suicides take place among teenagers. They are frequent among the aging population. Housewives may take their lives. So may the corporate executive. Poor people may kill themselves; so may the very rich.

In fact, suicide is a leveler common to all ages and all economic groups. It happens 25,000 times a year, and about 2,000,000 people in this country have made attempts on their own lives. Suicide is the second most frequent cause of death among college students. The elderly form another target group for self-destruction.

Is there a way in which this destructive trend can be halted and turned around? Are there known preventive measures which might be taken? And can intervention be effective for those people who are so depressed they are contemplating suicide or who are guilt-ridden because someone they love has done so?

An effective program in Dallas, Texas, may serve as a model. The Suicide and Crisis Center in Dallas, using hot lines and crisis intervenors, has demonstrated a successful method working in the areas of prevention, and intervention. When the Hogg Foundation for Mental Health was asked to help financially with a Suicide Attempters Program, the staff recognized the value of reaching the group of people who have attempted suicide and might do so again. Such demonstrations as this project may serve as models for other communities and may impact significantly on a problem which touches so many of us in some manner.

Bert Kruger Smith

THE TRAGEDY

The individuals quietly take seats in the room. They exchange perfunctory glances, each in his or her own world, carefully balancing the emotions so near the surface struggling to erupt. These are feelings familiar to some for several years, raw and fresh to others. The leader opens by gently acknowledging their shared pain and the sense of isolation, confusion, anger, and extreme guilt common to persons who have ached over a loved one's "killing himself, committing suicide." The very use of those words, validated by descriptions of feelings so intense as to be overwhelming, both establishes a bond and gives permission to relax the tight grip that has kept emotions in check.

The tears are flowing down the cheeks of Kay, a 25-year-old widow whose husband had killed himself six weeks earlier, leaving her with a three-year-old son and a broken motorcycle that filled the living room of their small apartment. As she tells her story, she is comforted by Joan, a tall woman whose brother had blasted a bullet into his brain two years earlier.

Confusion and the gnawing question, "Why?" mark the torment of Bill and Lois as they report their shock and anguish over the suicide of their 15-year-old daughter, Kari, who had been given all the love and attention they could invest in her, including nurturing her through a previous suicide attempt punctuated by several notes detailing Kari's despair at not being "understood."

Ted describes the deepening depression of his father, whose sales record has plummeted with the economy, taking his self-esteem with it. When Ted and his mother removed the .38 caliber revolver his father had talked about using to "end his worthless life," they did not consider that he would purchase the rope necessary to hang himself the next day in a secluded wood two miles from their home.

Over the next two months, this group—united by their status as "survivors of suicide"—would walk a path together that too often is traveled alone, navigating a grief experience magnified by feelings of guilt and unexpressed anger. The objects of their anger are not present to hear those feelings or to answer the questions about why, with so much to live for, they chose to end their lives.

The tragedy is that in many cases, the suicide was not the result of a desire to die, but a desire to end a psychic pain which seemed interminable and intolerable. Often the suicide followed veiled hints, overt threats, or even one or more actual suicide attempts, which

produced neither a cessation of the pain, nor improvement in coping skills, nor changes in patterns of relationships.

The clues that most persons (80% is the best estimate) give about their hopelessness and suicidal intentions reflect their ambivalence about the self-destructive course of action being considered. Verbal, behavioral, and situational clues may be explicit and dramatic (such as an attempt) or vaguely implicit. Unfortunately, the recipients often are ignorant of the clues' importance, or they may be too immobilized by fear to respond appropriately.

Verbal clues to be recognized and responded to range from those on the order of "You'd be better off without me" or "It doesn't matter what grade I get on that exam. . .I won't be around much longer," to such blatant expressions of hopelessness as "I'm going to kill myself." The myth that "talkers don't do it" is totally fallacious. Behavioral clues include depression and its symptoms of weight loss, sleeplessness (or their extreme opposites of weight gain and/or complete lethargy), loss of emotional zest and enjoyment, expressions of hopelessness, and actions (such as giving away prized possessions) indicative of making "final arrangements."

Situations that increase the likelihood of suicide include the death of a loved one, break-up of a significant relationship, problems with the law, and business or school failures. The mixed feelings and tension over improving a situation only by ending the pain at any cost often produce an immobilizing and depressive inertia. Without effective intervention, suicidal thoughts constrict rationality further, producing a "tunnel vision" that focuses on a self-destructive hopelessness to the exclusion of healthier options.

The constricted thinking and self-destructiveness do not necessarily reflect mental illness, although persons with a history of chronic mental illness, especially those diagnosed under the term "schizophrenia," are at a greater risk for suicide than the population at large. Other high-risk groups in our population include alcoholics and abusers of other drugs, homosexuals, and family members and friends of suicide victims.

All the above groups share life-styles or situations with a high likelihood of social isolation and loss of relational support during times of crisis. Although researchers are seeking biochemical or genetic links in suicidal behavior, it appears that a major factor contributing to the vulnerability of survivors is the "modeling effect" that produces behaviors similar to those one has observed in significant others. Temporary increases in suicides and deaths in single-car accidents immediately following the suicide deaths of famous people and television stars indicate that the significant others need not be blood relatives.

On the national level, statistics paint a fairly clear profile of the most likely suicide as being an older, Anglo male. Three out of four suicides are males, and the rate of suicide increases with age, despite alarming recent increases among teenagers and young, black males. Although 75 percent of all *completed* suicides are male, three out of four suicide *attempts* are by females.

These statistical pictures, while descriptive and illuminating, do not provide a foolproof way of accurately predicting who will commit suicide. That process is still exceedingly non-exact, as the group of "most likely" still contains so many who will not kill themselves that it is difficult to identify the high-risk population precisely. Such ambiguity explains to some degree the confusion and ineffectiveness among many caring lay persons, mental health professionals, physicians, ministers, teachers, law enforcement personnel, etc. Meanwhile, the tragedy escalates.

On a national level, suicide often takes young people in their productive years. It costs taxpayers, too, as the actual financial demands on a community by a single suicide have been estimated to range from $50,000 to $500,000 when emergency services, survivors' support, and lost productivity are calculated. Perhaps the greatest and most poignant impact is the direct and indirect toll that 35,000 suicides a year take on the survivors, on the hundreds of thousands of Kays, Joans, Teds, Bills and Loises.

THE HELPERS

The institutions, professionals, and lay people who are committed to reducing the tragic losses from suicide are handicapped by several obstacles, ranging from fear, lack of knowledge, and insufficient (or nonexistent) funding, to the social stigma which stifles the suicidal person's willingness to reach out of his or her hopelessness for help.

Institutions such as hospitals and state and county treatment facilities fight an uphill battle and many times concede rather than fight, or they often face the temptation to act out of self-interest rather than concern for the suicidal client-patient. Policies and procedures frequently are written to shield the institution from vulnerability to lawsuit as much as to protect, support, and treat the *patient.* Hospitals are slow to adopt such "expensive" measures as installing breakaway shower curtain rods and safety glass in windows, checking suicidal patients every 15 minutes at night or staffing acutely suicidal patients on a one-to-one basis, and taking the time to develop, document, and evaluate comprehensive in-hospital suicide prevention programs.

Recent movement toward prevention and health maintenance may indicate a reduction of emphasis by the "medical model" on pathology and application of solely remedial medical procedures. Allowing patients and their families to participate actively in their treatment not only is medically sound, but it also addresses the natural helplessness, fear, and powerlessness which are especially acute for the suicidal patient. As hospitals move toward a more holistic and multidisciplinary treatment model, they find that involving and utilizing such resources as ministers, social workers, therapists, and family systems produces patient benefits that far outweigh the increased need for warmth and communication by caregivers.

Penal institutions have long acknowledged, though privately, the high suicide rate among inmates in correctional facilities, especially just before being paroled and immediately following incarceration. Yet budgetary constraints, fear, ignorance, and a lack of concern often combine to maintain the suicide risk at a high level. Only infrequently implemented (and then usually out of fear or legal action) are such measures as teaching both corrections personnel *and* inmates skills of identifying and assisting (rather than collaborating with) the suicidal inmate, increasing the professional support network and related counseling programs for prisons (including access to a 24-hour crisis hotline), and close observation and attention to the suicidal inmate.

Tax-supported mental health programs for suicide prevention generally do not have priority, if they are addressed at all. Although individual case workers who have direct client contact are hungry for any crisis intervention skills and suicide information to support their services, funds are seldom allocated for qualified inservice training in crisis intervention and suicide assessment. Crisis lines, outreach services, and even face-to-face therapy often are the first victims of budget cuts which force institutions to provide bare-bones services to only the most severely dysfunctional clients. Follow-up services are minimal, especially for low-income clients who cannot afford private counseling or get into one of the rare private therapy programs that offer quality counseling on a sliding fee scale.

The suicidal patient who is seeking counseling support often experiences bewilderment and frustration as he or she enters that "system," usually with low reserves of self-esteem and psychic resources to deal with the frustrations of confronting a range of therapists. Some counselors will not work with clients expressing suicidal thoughts, and others automatically hospitalize them. Some therapists experience anxiety and fear about a perceived threat to their professional competence from suicidal clients, and many have little training and experience working with overt suicidal behavior and ideation. Training programs for clergy, police, and medical professionals rarely include an emphasis on suicidology, especially in a practical sense. In short, the conspiracy of silence that surrounds a suicidal person may include professionals as well as lay persons, and the boundary between professionalism and personal emotional responses is a most fluid and subjective one.

One crisis intervention center realized this obscurity in working with a certain minister and his wife. The couple's adult daughter had a history of suicidal behavior, including attempts. In dialogue with the family during an episode of Cheryl's depression, the center deferred to Reverend S's statement that hospitalization would not be necessary, as the family would watch Cheryl at home. The difficulty of meshing professional and personal judgment became tragically apparent when Cheryl got up from watching television with her parents on the day before her mother's birthday, went to her bedroom, and took a fatal dose of drugs. Intervening with suicidal persons warrants the support of consultation and assistance from a *broad* variety of helpers who are not afraid to communicate and relate warmth, genuineness, and effective hope to the suicidal person who generally feels "hopeless, helpless, and hapless" in his or her isolation.

The suicide attempter, despite the positive ambivalence and clues that express it, frequently acts out of the destructive side of that ambivalence, thus frustrating intervention opportunities. Because of the powerlessness of feelings of helplessness and hopelessness, the

suicide attempter may veil the clues too thoroughly or not give clues to persons capable of responding effectively. Following a suicide attempt, those feelings can be magnified by embarrassment or shame, which leads to denial of the intensity of the pain and an increased reluctance to seek help. Nevertheless, an important function is accomplished by the suicide attempt: it has called attention dramatically to the extent of the attempter's emotional pain, constricted thinking, isolation, and need for assistance and attention. The attempt readily identifies the person as a high risk for suicide unless other coping mechanisms are learned. In short, the accuracy of identification is enhanced, and with it the possibility of transforming the danger of the crisis into an opportunity for growth.

THE SUICIDE AND CRISIS CENTER

Suicide Prevention of Dallas was one of the community-based organizations that evolved during the late 1960s with the creative coalescing of telephone hot lines, the use of volunteer paraprofessionals as crisis intervenors, and a need which concerned people were not willing to allow go unmet. In the case of "SPC," as its family of volunteers fondly called Suicide Prevention of Dallas (the "C" was for "Center"), a layman who had experienced suicidal loss within his immediate family raised the idea of a suicide prevention hot line with a psychologist who attended the same church. The idea grew and was shared with others. As support grew and some limited financial resources were promised, the decision was made to incorporate and provide a service.

During the process of sharing the vision, the medical, mental health, religious and professional communities were consulted and became involved, sharing ownership to meet a need without the defensiveness of "turf" issues. Visits were made to observe and consult with the Los Angeles Suicide Prevention Center, the leader in the field. Training courses were designed, and volunteers were recruited, the decision to use volunteers being a most crucial one. On February 14, 1969, the first calls were taken by a cadre of counselors that included both lay people from all walks of life and mental health professionals.

From the beginning, volunteers—qualified only by nonjudgmental concern, an openness to growth, the ability to communicate, and an extraordinary commitment—formed the lifeblood of the agency. Exceptionally well-trained and supervised, they have kept the Crisis Line open for more than 13 years—24 hours a day, seven days a week, 52 weeks a year, on holidays and through natural disasters. Instead of being paid triple overtime, they were rewarded in heightened self-awareness, increased ability to cope in their own lives, and the unsurpassable satisfaction of having made major impact on the lives of persons teetering on the brink of self-destruction. Nearly 50,000 different clients called during SPC's first 13 years, many dialing several times to pour out intimate, vulnerable, anguished tales, each of which was met with respect, acceptance, and skill.

Through the years, a small, yet equally dedicated, professional staff was built. Many of the supervisory and administrative functions originally handled by volunteers were transferred to that staff, and new programs were added to enhance the Center's ability to meet the community's needs. In 1981, the agency responded to its expanded role by explicitly acknowledging what had long been the actual practice: in addition to being the agency that educated about and met the tragedy of suicide, it also was in fact a crisis intervention center. SPC became SCC: The Suicide and Crisis Center. Still, paraprofessional volunteers delivered the service to the client in need.

The programs of The Suicide and Crisis Center reflect the three facets of suicidology identified by Edwin Shneidman, co-founder of the Los Angeles Center and founder of the American Association of Suicidology. The three facets are prevention, intervention, and postvention. The Crisis Line forms the core program, for which volunteers are initially trained, and which functions as an *inter*vention program. Early in the life of the agency, it became apparent that prevention required increased public consciousness of the nature of suicide and the skills useful in intervening.

*Pre*vention involved community education, so that human crises could be resolved before the person reaches the actual end of his rope. A Speakers Bureau was developed which sends trained crisis counselors into schools, churches, and civic groups to explain ambivalence, to puncture misconceptions about suicide, and to challenge audiences to use warmth and listening skills to intervene in the pain of loved ones and friends. These Speakers Bureau appearances are the opportunity to intervene as well as educate, whether the person in pain is a junior high student or the president of the Chamber of Commerce.

The *post*vention facet is implemented through a Survivors of Suicide (SOS) program, in which trained and experienced volunteers work as facilitators for eight sessions with groups comprised of family members and friends of suicide victims. These groups provide a safe setting where persons who are experiencing such a loss can express their feelings openly (which often is scary in other settings, both for loved ones and for themselves), learn about the grief process, build a support group, and expand their ability to adapt.

As the quality of the Center's training program became recognized, the staff began offering professional consultation and in-service training programs. In a recent year, for example, over 70 outside training programs were conducted with such groups as school counselors, social service agencies, other crisis agencies, police training academies, and county mental health-mental retardation centers. These programs are made current by ongoing research, such as a comprehensive study funded by the Junior League of Dallas and entitled, "Teen Suicide in Dallas County."

THE SUICIDE ATTEMPTERS PROGRAM

In 1981, the Hogg Foundation for Mental Health made available the resources to initiate a major creative program which extended the Suicide and Crisis Center's ability to intervene in the tragedy of suicide. The Suicide Attempters Program combines postvention and prevention in its work with a high-risk group—persons who have made a suicide attempt. Not only are these persons at high risk, but they also are a group which easily "falls through the cracks" in the mental health delivery system. This program uses the Center's training skills and knowledge of suicide not only to provide a needed service to clients but also to stimulate networking and links among the varied agencies and institutions that come in contact with suicidal people.

The program is made up of three separate but interrelated services: training for hospital personnel, the Outreach Team, and a support group for recent attempters. Each service is designed to meet a specific need within the community. Together they offer ongoing support to those individuals who have recently tried to end their lives.

Education

Perhaps the least glamorous, but most important, of the Center's many services is its training program for hospital emergency room personnel. Nurses, interns, paramedics, chaplains, and secretaries have participated in this in-service training conducted at local hospitals by the Center staff. Generally from four to six hours in length, the sessions cover such topics as the dynamics of a crisis, assessment of suicidal risk, and techniques for effective intervention. Particular emphasis is placed on teaching the critical skill of active listening, how to communicate with the attempters to facilitate the exploration of feelings and help focus on alternative solutions. In addition, the program offers those in the helping professions suggestions on how to cope better with their own fear and frustration, emotions often experienced in work with suicidal individuals.

Outreach

The Outreach Program, funded by the employees of the Safeco Insurance Company, consists of male-female teams pairing a trained volunteer and a staff professional who meet face-to-face with clients in crisis who have no other resources and are at immediate risk for a suicide attempt. Since loneliness and despair do not keep office hours, the teams are on call around the clock. Midnight counseling sessions conducted at all-night restaurants or hospital emergency rooms are not uncommon. Sometimes, with the help of the counselors, the potential attempter is able to resolve the immediate crisis and discard the idea of suicide. At other times, the team acts to provide support for the suicidal individual during the often frightening process of hospitalization.

Although the Outreach Teams have been functioning for only a short time, the community's response has been overwhelmingly positive. Without exception the individuals in crisis have been deeply touched by the team's visits. As one young woman told the counselors when they arrived at her home late one evening, "I didn't believe you would come; I didn't think anybody really cared." To this young woman, as to many others, the Outreach Team sends a clear message that "Yes, we do care."

Support Group

The third component of the program, a group for recent suicide attempters, provides these troubled individuals with a support system within which they can express, confront, and resolve their thoughts of suicide and feelings of helplessness and hopelessness. For some, this can be accomplished within a few weeks. For others, especially those who have made repeated attempts, the process may take much longer. There is no limitation on the length of time a person can attend the group. Those who leave know that they are free to return should thoughts of suicide reoccur.

The group meets for one and one-half hours each week. There is no charge, so that attempters from all income levels may attend. Although some of the group members are also in individual therapy, most cannot afford a private therapist. Members enter the group in various ways. Some are referred by police social workers, others by hospital staff who have identified a need for the attempter to continue some form of therapy following discharge from in-patient treatment. Still other attempters learn of the program from family members, friends, or SCC telephone counselors.

The group is led by two mental health professionals, one of whom is on the Center staff; the other donates the time spent with the group. It is the Center's hope that as the need for additional groups develops, mental health professionals within the community will continue to contribute their time and energy as group leaders and as consultants to the group.

Jennifer's story may illustrate how the varied aspects of the Center's programs intermesh. A lonely young woman who represents the many suicidal individuals who contact the Center, Jennifer is 28. She lives in a tiny apartment with her two preschool children and her alcoholic mother. Since her divorce a year ago, she has been the sole support of her family, working nights at a fast food restaurant. As the months passed, Jennifer gradually became increasingly overwhelmed by the task of supporting four people on her meager salary and angry at her ex-husband for his lack of concern and financial support. To Jennifer, her unhappiness became unbearable the night she learned that she had lost her job at the restaurant. In her eyes, life no longer seemed worth living, and she could see no chance for future happiness for herself, only loneliness and disappointment. Like many other suicidal people, she rationalized that her family would be better off without their depressed and now unemployed mother.

Jennifer decided that death was the only logical solution to her pain. She swallowed a handful of pills that she found in her medicine cabinet. Yet a part of her still wanted to live. Frightened, she dialed The Suicide and Crisis Center, still not sure she wanted help. The volunteer telephone counselor recognized Jennifer's ambivalence and took the time to listen to her despair as well as to her fear of dying. Because of Jennifer's reluctance to go to the hospital, the telephone counselor offered to send two counselors from the Center's Outreach Team to meet her at the emergency room. With the promise of someone waiting for her, Jennifer agreed to go to the hospital. The phone counselor called the police and Jennifer willingly went with them to the hospital emergency room.

At the hospital, Jennifer was relieved to find the two Outreach counselors waiting for her. After Jennifer was treated by a physician, the two counselors sat with her until she could be seen by a psychiatrist. As they waited, they continued the process already begun by the telephone counselor of recognizing and reflecting back to Jennifer her feelings of anger toward her ex-husband and her despair over her failure to keep her job. Encouraged by the counselors' respect and understanding, Jennifer began to consider alternatives to suicide.

By the time she spoke with the psychiatrist, she was open to accepting the suggestion that she begin individual therapy at the hospital clinic and that she join the support group for suicide attempters

sponsored by The Suicide and Crisis Center. In Jennifer's case, hospitalization could be avoided partly because of the existence of a support group for her within the community.

What might Jennifer find when she attends the group? Probably surprise and relief to find other group members to be much like herself. Here is a place where she will be allowed to talk openly about her feelings of hopelessness and her thoughts of suicide. As one member, Bill, remarked, "Some of these things you just don't dare unload on somebody on the outside. If you tell somebody outside that you're teetering on the brink of suicide, they'll get very upset or very angry." Judy, another member, adds that family and friends, "get all shaky and think you're just pulling the wool over their eyes; they want to see it as a joke because they can't accept the seriousness of what you're saying or they don't know how to help, so instead of doing anything they just back off, which is really the thing you need least."

Instead of "backing off," the group members listen, share experiences, offer encouragement and suggest new ways of looking at problems. They discover that they are not alone with their feelings, that others have experienced similar difficulties. Often they recognize themselves in the words of others and thus gain a new perspective on their own behavior.

Many of the group members live alone and have few close friends. For these people, as Judy put it, "The group is an outlet to share joy and anger and all of the emotions that you really want to share with someone but there's just nobody there to share it with."

Certainly the group is not the complete solution to the loneliness and isolation experienced by its members, but for many it is the beginning of a new hope, new friendships and new ways of coping with life's inevitable problems.

CONCLUSION

The Suicide Attempters Program of The Suicide and Crisis Center is not perfect, nor are any of its other programs. However, in this imperfect world, imperfect solutions are better than no solutions. These programs can be duplicated on almost any level. In fact, the size of the Dallas–Ft. Worth Metroplex is so great that often the problems are so pervasive as to discourage would-be helpers, whereas a smaller community might find its problems more manageable, even with limited resources.

One advantage of these programs is their effective utilization of volunteers, which not only cements the programs with dedication and caring, but also makes them efficient. A cost of $5 per client contact is amazing compared to the costs of programs not using paraprofessionals. One fact of volunteer programming, however, is that its effective use requires competent and talented supervision in order to recruit, train, motivate and retain quality volunteers. Today's volunteers demand more personal growth and more meaningful volunteer experience. More and more are employed outside the home, and the challenges of the workplace raise the level of what they hope to find in volunteer service.

Quality control and professionalism are key ingredients in building crisis intervention and suicide prevention programs. In the last three decades, crisis intervention has achieved recognition as a distinct discipline in its own right, with a specific knowledge base and practice. Rather than "band-aid," crisis intervention is emergency emotional first aid. Effectively-operated crisis lines are a far cry from rap lines or information and referral services, both of which have their appropriate places.

Fortunately, specific standards for the operation of crisis services exist. These are stated and maintained by the American Association of Suicidology, which offers a certification program for crisis intervention/suicide prevention programs. The AAS standards cover the seven areas of administration and organization, ethical issues, training, general crisis services, suicide services, community integration, and program evaluation. A community considering instituting suicide or crisis services, and especially those considering using volunteers in a meaningful say, would be wise to consider corresponding with the AAS Central Office in Denver or consulting with an AAS-certified center such as The Suicide and Crisis Center in Dallas.

The trial-and-error, seat-of-the-pants approach of the 1960s will not survive today, when tight resources compel foundations, govern-

ments, and individuals to demand more accountability from agencies where they invest either time or money. For that same reason, communities can be optimistic about the advantages in terms of effective, efficient services to be achieved in preventive crisis programs that utilize well-trained and supervised paraprofessionals.

Personal human stories communicate the impact that committed persons can have with the support of communities and institutions that care. It is not an especially easy task to change self-destructive behavior patterns that may have been developed over years of living in loveless, discounting situations and in families who make it clear "we'd be better off without you." It is not easy to educate teachers such as the one who ignored the nine-year-old boy who at the end of the school term said he wouldn't be back next year because he was going to kill himself—and did. It is not easy to mobilize a society to fund programs for the elderly, who have the highest rate of suicide in the nation. It is not easy to get funders and conservative, ponderous school district to acknowledge the stark threat in the fact that the suicide rate among teenagers has tripled in the last two decades.

Yet there are those who respond. They boldly identify the problems that plague us and creatively combat them. Together they form a powerful community which can make a significant difference in the lives of people in pain, to improve the quality of life in our society.